



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name and Address**

MEMORIAL HERMANN HEALTHCARE SYSTEM  
3200 SOUTHWEST FREEWAY ST 2200  
HOUSTON TX 77027

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Tracking Number**

M4-07-2663-02

**MFDR Date Received**

December 29, 2006

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred."

**Amount in Dispute:** \$25,014.24

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Division of Workers' Compensation, then the Commission, contracted with Ingenix, Inc., in 2002 to develop MARs for a hospital outpatient fee guideline. Ingenix recommended to the Commission that a market reimbursement of 140% of Medicare's Hospital Outpatient Prospective Payment System (HOPPS) would meet the statutory requirements of Section 413.011(d). . . . Texas Mutual initially paid \$2.01, for unknown reasons. This is \$4832.85 less that he Ingenix recommended MAR. Texas Mutual will issue a supplemental check for this amount under separate cover."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

**SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2005	Outpatient Hospital Services	\$25,014.24	\$0.00

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 29, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 16, 2007

to send additional documentation relevant to the fee dispute as set forth in the rule.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
  - CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
  - 731 – 134.801 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95<sup>TH</sup>-DAY AFTER THE DATE OF SERVICE, FOR SERVICES ON OR AFTER 9/1/05.
  - 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.

## **Findings**

1. Per 28 Texas Administrative Code §134.801(c)(2), effective November 3, 2005, 30 *Texas Register* 7626, applicable to dates of service on or after September 1, 2005, states that “A health care provider shall not submit a medical bill later than . . . the 95th day after the date the services are provided, for services provided on or after September 1, 2005.” Review of the submitted information finds no documentation to support that the health care provider submitted the medical bill to the insurance carrier before the 95th day after the services were provided. The requestor does not discuss or address these denial reasons in the submitted position statement. The Division finds no information to support that the requestor met the requirements of §134.801(c)(2).
2. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include “a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB.” Review of the submitted documentation finds that the request does not include a copy of the EOB detailing the carrier response to the provider's initial bill. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B).
5. Former 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send “a copy of any pertinent medical records.” Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
6. Former 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include “a description of the healthcare for which payment is in dispute.” Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
7. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
8. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
  - The requestor's position statement asserts that “a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred.”
  - The requestor did not submit documentation to support that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred.

- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline*, that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors” (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they “allow the hospitals to affect their reimbursement by inflating their charges” (22 *Texas Register* 6268-6269). Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

**Authorized Signature**

	Grayson Richardson	July 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**